DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/30/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185314	A. BUILDING _____ B. WING _____	C 08/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER TRACE NURSING HOME	116 PIONEER TRACE FLEMINGSBURG, KY 41041

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An Abbreviated Survey investigating ARO #KY00015162 was initiated on 08/11/10 and concluded on 08/13/10. ARO #KY00015162 was found to be unsubstantiated; however, deficient practice was identified at 483.13, F226 at a Scope/Severity of an "E" level; and at 483.20, F281 at a Scope/Severity of a "D".	F 000	F 000 This plan of correction is not meant to establish any standard of care, contract obligation or position and Pioneer Trace Nursing Home reserves the right to raise all possible contentions and defenses in any type of civil or criminal claims, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver to any potentially applicable peer review, quality assurance or self critical examination privileges which Pioneer Trace Nursing Home does not waive and reserves the right to assert any administrative, civil, or criminal action or proceeding. Pioneer Trace Nursing Home offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure written policies and procedures were implemented related to abuse prevention. Resident #1 made an allegation of abuse; however, the facility failed to implement it's Abuse Prevention Plan regarding the protection of residents during their investigation. The findings include: Review of the facility's Abuse Prevention Plan, revised on July 2009 revealed, "Residents will be protected from harm during the investigation by seeing their care needs are met promptly". 1. Review of the clinical record revealed Resident #1 was admitted to the facility on 09/16/03 with diagnoses which included Mental Retardation and Depression. Review of the Annual Minimum Data	F 226		

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BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Julie Watson — Administrator — 9/10/10

y deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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F 226	Continued From page 1 Set (MDS) Assessment dated 07/15/10, revealed the facility assessed Resident #1 as having short-term memory deficit and modified independence with cognitive skills for daily decision making. Further review of the MDS revealed no documented evidence of any mood and behavior patterns. However, the MDS did reveal, Resident #1 had been evaluated by a licensed mental health specialist in the last ninety (90) days and had received an anti-depressant, Celexa. The facility assessed Resident #1 to require supervision to limited assistance of one (1) staff member for locomotion on or off the unit. Review of the facility's investigation and timeline of events revealed on 08/02/10 at approximately 11:00 AM, Resident #1 was crying and informed an aide that Resident #2 had pulled the sheets off his/her bed. On that same day at approximately 11:15 AM, Resident #1 told a nurse a resident had grabbed him/her in the genital area, while clothed. Review of the Social Worker's Investigative Notes, dated 08/02/10, revealed Resident #1 stated a male resident entered his/her room and grabbed Resident #1's genital area. Resident #1 also indicated his/her breast were touched. Additional review of the Social Worker's Investigative Notes revealed Resident #1 stated, "that man came in my room and put his hands in my vagina, then he was kissing and grabbing my breasts". During an interview with Resident #1 on 08/12/10 at 4:00 PM the resident stated Resident #2 put his/her "finger up inside me. Resident #1 then indicated he/she did not want to talk about it and stated, "I'm so embarrassed".	F 226	F 226 Facility Administration was attempting to clarify Resident #1's allegation since the allegation changed from the CNA report to the LPN report prior to taking away Resident #2's right to privacy, although the facility did identify Resident #2's whereabouts during the time in question prior to placement of 1-1 staff monitoring and Resident #2 was in staff monitored areas during the time in question. The Social Services Director interviewed Resident # 2 on 08/02/10 and he stated he had not been in Resident #1's room and did not touch her inappropriately in any way. The Social Services Director interviewed staff working on 08/02/10 and staff revealed they had not seen Resident #2 in Resident #1's room and actually had not seen Resident #2 anywhere near Resident #1's room. The Social Services Director interviewed alert and oriented residents in regards to sexually inappropriate behavior from residents or staff on 08/17/10. No concerns were identified. The Social Services Director and DON interviewed staff and reviewed residents charts of the remaining residents and no additional residents were found to be affected by the deficient practice.	

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F 226	Continued From page 2 2. Resident #2 was admitted to the facility, with a stay projected to be of a short duration, on 04/22/10 with diagnoses which included Right Arm Amputation, Chronic Renal Failure and Chronic Obstructive Pulmonary Disease (COPD). Review of the Admission MDS Assessment dated 05/04/10 revealed the facility assessed Resident #2 as having short-term memory deficit, and modified independence with cognitive skills for daily decision making. The facility assessed Resident #2 to be totally dependent with locomotion on or off the unit. During an interview with Resident #2 on 08/12/10 at 11:00 AM the resident stated he/she had never been in Resident #1's room or touched the resident inappropriately. Observation of Resident #2 on 08/12/10 at 11:35 AM revealed, Resident #2 was able to ambulate with minimal assistance of one (1) staff member. Interview with Certified Nursing Assistant (CNA) #1 on 08/12/10 at 1:40 PM revealed, CNA #1 entered Resident #1's room at approximately 11:00 AM on 08/02/10 and observed Resident #1 to begin to cry. CNA #1 stated, Resident #1 revealed he/she was crying because Resident #2 had entered his/her room, grabbed the resident's sheet and got chocolate on the sheet. CNA #1 also revealed, the allegation was reported immediately to Licensed Practical Nurse (LPN) #1. Interview with CNA #2 on 08/12/10 at 2:25 PM confirmed the information CNA #1 provided during interview (CNA #2 was also in the room). Interview with Licensed Practical Nurse (LPN) #1 on 08/12/10 at 3:30 PM revealed, CNA #1 and CNA #2 reported Resident #2 had pulled on	F 226	Facility Administration implemented protocol for all staff to follow if an allegation of abuse is alleged, which includes immediately placing all residents involved in the allegation on 1-1 staff monitoring until deemed appropriate for 1-1 monitoring to be discontinued. Staff was in-serviced on implementation of 1-1 staff monitoring for allegation of abuse on the following dates, 08/19/10, 08/20/10, 08/21/10, 08/23/10, and 09/01/10 by the DON, Unit Coordinator and SSD. Facility Administration reviewed the current abuse prevention plan on 08/18/10 and staff was in-serviced on the following dates, 08/19/10, 08/20/10, 08/21/10, 08/23/10 and 09/01/10 by the DON, Unit Coordinator and SSD. Facility Administration implemented a new protocol for alleged abuse using an acute plan of care for alleged abuse (Attachment A). All staff was in-serviced on the new protocol for abuse allegations using the new acute plan of care on the following dates, 08/19/10, 08/20/10, 08/21/10, 08/23/10, and 09/01/10 by the DON, Unit Coordinator and SSD. The Director of Nursing and Social Services Director will be responsible for evaluating staff implementation of the Abuse Prevention Plan and the acute plan of care for alleged abuse. The Director of Nursing and Social Services Director will report all findings to the Administrator	

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F 226	Continued From page 3 Resident #1's bed sheets. LPN #1 revealed, Resident #1 told her Resident #2 entered the room and grabbed me. LPN #1 stated, Resident #1 pointed to the vaginal area when it was stated Resident #2 grabbed Resident #1. The nurse stated, Resident #1 was questioned about the sheet being grabbed and Resident #1 replied, no. She also revealed, attempts were made to contact the Social Worker but the Social Worker was out of the facility, and the nurse informed the Director of Nursing about the allegation, immediately. Interview with the Social Worker on 08/12/10 at 1:00 PM revealed, Resident #2 had been questioned on 08/02/10 at 1:30 PM by the Social Worker, regarding the allegation on 08/02/10. Review of the Social Worker's Investigative Notes, dated 08/02/10 revealed Resident #2 stated he/she had not been in Resident #1's room, that day. Interview with the Director of Nursing (DON) on 08/12/10 at 1:15 PM revealed, the incident occurred sometime after breakfast, around 9:00 AM. The DON, the Social Worker and the Nursing Home Administrator (NHA) interviewed Resident #1 at 3:00 PM on 08/02/10, about the allegation. Per the DON, this interview revealed, Resident #1 stated Resident #2 had touched the resident's vaginal area while the resident was fully dressed. Per the investigative notes Resident #1 indicated Resident #2 had placed a hand in Resident #1's vagina and squeezed and kissed the resident's breasts. Interview with the Activities Director on 08/13/10 at 2:15 PM revealed, Resident #1 and Resident #2 attended a game of BINGO together, on	F 226	immediately and to the Quality Assurance Committee (comprised of the Administrator, DON, Unit Coordinators, Medical Director, MDS Coordinator, SSD, Consulting Pharmacist, and Owners) monthly. The Administrator and the Quality Assurance Committee will review the results reported regarding staffs implementation of the Abuse Prevention Plan and the acute plan of care for alleged abuse and will track and trend the results to determine if changes are needed or further staff education is warranted.	09/02/10

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F 226	Continued From page 4 08/02/10, the day the allegation had been made. The Activities Director indicated being aware that something had happened and kept an eye on Resident #2. However, he/she had never been officially informed about the allegation or the need to supervise Resident #2. Interview with CNA #3 on 08/13/10 at 2:20 PM revealed, this aide had been informed of the allegation by the DON and was assigned to provide one (1) to one (1) supervision at 2:30 PM on 08/02/10, for Resident #2. Interview with CNA #4 on 08/13/10 at 2:35 PM revealed, CNA #4 was assigned to care for Resident #2, the day the allegation was made on 08/02/10. Further interview revealed the CNA was not informed about the allegation until the following day, on 08/03/10. Interview with LPN #2 on 08/13/10 at 2:45 PM revealed, LPN #2 was assigned to care for Resident #2 on 08/02/10 and the DON did not inform LPN #2 about the allegation and need for one (1) to one (1) supervision with Resident #2 until between 2:30 PM and 3:00 PM on 08/02/10. Interview with the Nursing Home Administrator on 08/13/10 at 1:15 PM revealed the facility did not implement interventions to protect Resident #1 until 2:30 PM on 08/02/10. Resident #2 was placed on one (1) to one (1) supervision to protect other residents from 08/02/10 at 2:30 PM to 08/05/10 at 11:00 AM.	F 226	F 281 When Resident # 1 alleged to the LPN that Resident # 2 grabbed her in the vaginal area, Resident # 1 said she was fully clothed, at that time LPN did not feel a skin assessment was appropriate and Resident #1 had not made an allegation that would have triggered the LPN to instruct the CNA's to avoid showering Resident #1. Resident #1 made the allegation of Resident #2 placing his hand inside Resident #1's vaginal area after the CNA's had given Resident #1 a shower, where the CNA's performed a visual skin assessment per standard procedure and no areas of concern were identified. Resident #1 then left the facility per physician order for a sexual assault exam to be performed by a qualified professional. Resident #1 returned to the facility and a skin assessment was performed on 08/03/10 with no areas of concern noted. A review of Resident #1's chart by the Director of Nursing on 08/03/10 did not identify any unexplained injuries of any nature. Review of Resident #2's chart by the DON on 08/03/10 did not identify any unexplained injuries of any nature. The Social Services Director interviewed Resident #2 on 08/02/10 and he stated he had not been in Resident #1's room and did not inappropriately touch her in any way.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide or arrange services which meet professional standards for one (1) of three (3) sampled residents (Resident #1). The facility failed to provide Resident #1 with a timely assessment, after an allegation of sexual abuse was reported. The findings include: Resident #1 was admitted to the facility on 09/16/03 with diagnoses which included Mental Retardation and Depression. Review of Resident #1's Annual Minimum Data Set (MDS) Assessment dated 07/15/10, revealed the facility assessed Resident #1 as having short-term memory deficit, and modified independence with cognitive skills. Further review of the MDS revealed the facility assessed Resident #1 as receiving Celexa (antidepressant medication). Interview with Certified Nursing Assistant (CNA) #1 on 08/12/10 at 1:40 PM revealed, she entered Resident #1's room at approximately 11:00 AM on 08/02/10 and Resident #1 made an allegation that Resident #2 had grabbed the sheet and got chocolate on it. CNA #1 immediately reported the allegation to Licensed Practical Nurse (LPN) #1. Interview with LPN #1 on 08/12/10 at 3:30 PM revealed, LPN #1 immediately went to Resident #1's room and Resident #1 stated Resident #2 had grabbed Resident #1 in the vaginal area, (the resident pointed to the vaginal area). LPN #1	F 281	Resident # 2 physician was notified of the allegation on 08/02/10 and no professional services were warranted or ordered by the physician as a result of the allegation. Social Services Director interviewed all alert and oriented residents in regards to any experiences of sexually inappropriate behavior from other residents or staff on 08/17/10. No concerns were identified. The Social Services Director and DON interviewed staff and reviewed residents charts of the remaining residents and no additional residents were found to be affected by the deficient practice. Facility Administration implemented protocol for nursing staff to follow which includes performing and documenting a head to toe skin assessment immediately upon an allegation of physical abuse, sexual abuse, neglect or involuntary seclusion. (See Attachment A) Facility Administration also implemented protocol for nursing staff to follow instructing staff to not give a resident a shower if any of the above types of abuse were alleged until cleared by the residents' physician. (See Attachment A) Nursing Staff was in-serviced on the new protocols on the following dates, 08/19/10, 08/20/10, 08/21/10, 08/23/10, and 09/01/10 by the DON, Unit Coordinator and SSD.	

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F 281	Continued From page 6 Immediately tried to reach the Social Worker but was unsuccessful. LPN #1 then notified the Director of Nursing (DON) about the allegation. LPN #1 revealed, the physician was notified and an order to send Resident #1 to the hospital was received at approximately 3:00 PM to 3:30 PM on 08/02/10. LPN #1 also indicated, Resident #1 was transported to the hospital around 5:00 PM on 08/02/10. LPN #1 indicated an assessment was not completed on Resident #1 prior to sending the resident to the hospital. Further interview revealed the resident had received a shower, prior to being sent to the hospital. Interview with the Nursing Home Administrator (NHA) on 08/12/10 at 1:45 PM revealed, Resident #1 was interviewed at approximately 3:00 PM on 08/02/10. During the interview, Resident #1 alleged Resident #2 had placed a hand inside Resident #1's vaginal area earlier that morning. Interview with the NHA on 08/13/10 at 1:15 PM, revealed CNA #6 showered Resident #1 around 1:00 PM on 08/02/10 and a skin assessment had not been completed. Interview with the NHA revealed, a full assessment of Resident #1 was not completed until 08/03/10, (the next day) at 10:30 AM by the Unit Manager.	F 281	The Director of Nursing and Unit Coordinators will be responsible for evaluating staff implementation of the new protocols whenever there is an allegation of abuse. The Director of Nursing and Unit Coordinators will report all findings immediately to the Administrator and monthly to the Quality Assurance Committee. The Administrator and Quality Assurance Committee will review the results reported regarding staffs implementation of the new protocols and will track and trend the results to determine if changes are needed or if further staff education is warranted.	09/02/10

Attachment A

Resident Name **Room#** **Physician:**

Goals	Approaches	Discipline	Date Added	Date D/C	Comments/Evaluation of goals
Resident will remain free from any further alleged abuse and will feel safe and secure in their environment through:	1. Report allegation of abuse to charge nurse immediately	All			
	2. If allegation involves a resident to resident incident, immediately place 1-1 staff monitoring with each resident in separate locations in the facility.	Charge Nurse			
	3. If allegation involves a staff member, immediately have staff member clock out and leave facility and remain on suspension until investigation is complete.	Charge Nurse			
	Immediately place 1-1 staff monitoring with resident.				
	4. Immediately report allegation of abuse to DON, SSD or Administrator.	Charge Nurse			
	5. Immediately report allegation of abuse to MD and Responsible party.	Charge Nurse			
	6. If physical abuse, sexual abuse, neglect or involuntary seclusion is alleged, immediately complete a head to toe skin assessment and document your findings. DO NOT SHOWER RESIDENT(S) UNTIL DEEMED APPROPRIATE BY MD.	Charge Nurse			
	7. If medical attention is required follow standard nursing procedure for injuries.	Charge Nurse			
	8. Follow any MD orders.	Charge Nurse			
	9. Allow resident(s) to verbalize feelings, concerns, thoughts to appropriate staff.	Charge Nurse, SSD			
	10. Provide a safe environment for resident(s).	All			

Assigned Staff Member for Monitoring:_____
Monitoring start time:
Monitoring end time:
Date:_____

Assigned Staff Member for Monitoring:_____
Monitoring start time:
Monitoring end time:
Date:_____

Assigned Staff Member for Monitoring:_____
Monitoring start time:
Monitoring end time:
Date:_____

Assigned Staff Member for Monitoring:_____
Monitoring start time:
Monitoring end time:
Date:_____

Problem/Need: Report of Alleged Abuse

Specify Type: Sexual _____ Physical_____ Verbal_____ Misappropriation of Property_____ Involuntary Seclusion_____ Mental____ Neglect_____